# Emergency health record

Howard S. Billings High School/2023-2024

**STUDENT IDENTIFICATION**

Family name: _____ First name: _____ Gender: ❑ Female ❑ Male

Address: _____ Date of birth: _____
Year Month Day

**EMERGENCY PHONE NUMBERS (PLEASE PRINT)**

| PARENT 1: | PARENT 2: | OTHER CONTACT: |
|---|---|---|
| Family name: | Family name: | Family name: |
| First name: | First name: | First name: |
| Relationship: | Relationship: | Relationship: |
| Hone phone : | Home phone : | Home phone : |
| Cell phone : | Cell phone : | Cell phone : |
| Other phone : | Other phone : | Other phone : |
| Email: | Email: | Email: |

To ensure your child's safety, you must inform the school of any health problems that **may require an emergency intervention at school** (severe allergy to certain foods or insect bites, diabetes, etc.).

**Does your child have this type of health problem? ❑ Yes ❑ No**
**If yes, please fill out the reverse side of this form.** ⟹

Please **notify the school of any changes** that occurs during the school year.
**If your child takes any medications on a regular basis, please attach the list of medications to this record in the event we need to call an ambulance.**

I authorize the school nurse and staff to read the information contained in this health record; I also authorize the nurse to examine my child, under 14 years of age, at the school's request (e.g., lice, pain, signs of infection).

_____ _____

Signature of parent, guardian or student age 14 and over. Date: Year Month Day

FAMILY NAME AND FIRST NAME OF THE STUDENT: _____

**IS THERE A POSSIBILITY THAT YOUR CHILD MIGHT REQUIRE EMERGENCY MEDICAL TREATMENT, SUCH AS:**

**Severe allergy requiring an adrenaline injection:**

Food ❑ Yes Specify: _____
Insect bite ❑ Yes Specify: _____
Other ❑ Yes Specify: _____

**Medication at school: AUTO-INJECTOR:** ❑ Yes which one: _____ Exp. date: _____
❑ No
Other: _____

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**Diabetes** ❑ Yes Administration of insulin required at school: ❑ Yes ❑ No
❑ Pen ❑ Pump Specify: _____

**Other medication at school:** ❑ Yes which one: _____
❑ No

→ **Please provide the nurse with a medical care plan.**

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**Epilepsy**: ❑ Yes Medication at school: Specify which one: _____

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**Other (e.g., asthma)**

Does your **child** have another health problem that may **require an emergency intervention at school?**
❑ Yes Specify: _____
❑ No

Does your **child** need **medication** at school?
❑ Yes Which one: _____
❑ No

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**ANYONE WITH A SPECIFIC HEALTH CONDITION THAT REQUIRES AN EMERGENCY RESPONSE SHOULD WEAR A MEDICALERT OR SIMILAR TYPE OF BRACELET.**

**THE INITIAL EVALUATION MADE BY THE NURSE IS VALID FOR A DURATION OF TWO YEARS.**
**PLEASE INFORM THE SCHOOL AND THE NURSE FOR ANY CHANGE.**

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Reserved for the nurse

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